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# PROJECT CONCERN INTERNATIONAL

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**CHILD SURVIVAL X:**  
***Improving Immunization Coverage and Village Health Post***  
***(posyandu) Implementation***

Maluku Province, Indonesia

September 30, 1994 - September 29, 1997

## MIDTERM EVALUATION REPORT

September, 1996

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## LIST OF ACRONYMS

<b>AusAID</b>	Australian Agency for International Development
Camat	sub-district head
Kader	volunteer village posyandu worker
LAM	Local Area Monitoring system
LPPM	Lembaga Partisipasi Pembangunan Masyarakat (Organization for Community Development Participation)
MANISE	Managemen Imunisasi Setempat (Immunization Management in the Workplace)
MOEC	Ministry of Education and Culture
MOH	Ministry of Health
<b>NGO</b>	Non-Governmental Organization
PAMIJPIN	Pasukan Murid PIN (Student Forces for National Immunization Week)
Penilik	sub-district education supervisor
PIN	National Immunization Week
PMT	Posyandu Management Team
PPAS	Program Posyandu Anak Sekola (School Posyandu Program)
PWS	same as LAM
TBA	Traditional Birth Attendant
UKS	School Health Effort
<b>USAID</b>	United States Agency for International Development

## EXECUTIVE SUMMARY

Project Concern International has worked in Indonesia for 24 years, managing public health projects focusing on maternal and child health and HIV/AIDS prevention. The Child Survival X project in Maluku is an outgrowth of these previous efforts, and has benefitted **from** the experience gained by PC1 elsewhere in Indonesia. The school *Posyandu* program now being **successfully** implemented in primary schools throughout Maluku was originally conceived as part of PCI's child survival project in Southeast Sulawesi during the mid- 1980s. It has been refined in Maluku, and will be introduced into still further areas as part of PCI's new CS-XI project in Irian **Jaya** province.

The midterm evaluation team was very impressed with the achievements of PCI's CS-X project in Maluku, and feels that this project can provide valuable lessons for other PVOs attempting to work in similar areas. With only a very few exceptions, the project is well on its way toward meeting its objectives and, upon its completion, should leave behind a much stronger health service delivery system in Maluku province.

The focus of the project is on strengthening the capacity of the MOH at all levels to provide health services and promote their use. Toward these ends, PC1 has developed a number of innovative strategies. To strengthen the **MOH's** management of its immunization program, PC1 designed *MANISE*, a computerized database system which greatly facilitates data compilation and reporting. MOH staff trained on the system have found *MANISE* to be convenient and easy to use.

In response to poor immunization performance at some health centers, PC1 introduced a peer immunizer training program, in which highly successful immunizers are assigned to visit and assist low-performing ones to improve their immunization management. An evaluation of this program showed that it led to substantial increases in vaccine doses delivered and improvement in cold chain management practices.

To broaden the reach of the **MOH's** National Immunization Day sweeping campaigns, PC1 organized a program called *PAMUPIN* which trains fourth, fifth and sixth grade students to help register mothers with children under five and escort them to the nearest immunization post during the campaign. This creative strategy, building on the success of PCI's school *Posyandu* program at mobilizing youth, was instrumental in increasing polio vaccine coverage in the areas where it was carried out.

Probably the most successful component of PCI's project has been the school *Posyandu* program, tapping the abundant energy of Maluku's school children to educate their families and communities about health issues and to promote the use of *Posyandu* health services. An evaluation of this program demonstrated a substantial increase in *Posyandu* attendance and immunization coverage, as well as improved knowledge of health and nutrition issues among mothers. The school *Posyandu* program has been formally incorporated into the fourth grade curriculum in Maluku province. PC1 is now working to replicate this program in Irian **Jaya** and Sulawesi; and the Ministry of Education and Culture is interested in making it a formal part of the national fourth grade curriculum.

Despite these notable successes, PC1 has been constrained by a shortage of funds in the CS-X project, which may prevent it from achieving all of its planned objectives. The amount of money provided by USAID for the Maluku CS-X project, **\$1,190,634**, is only 75% of the amount PC1 had proposed for this project, and is being used within a shorter time frame. Thus, USAID funding covers only 75% of the total project budget, and PC1 is relying on other sources of **funds** to support some of its activities. Two important project components, Posyandu kader training and TBA refresher training, may have to be cut back considerably or eliminated, because **funding** was not made available by the MOH, as originally agreed. A “lesson learned” for **future** child survival funding is to recognize that substantial reductions in proposed funding levels or timing, will have adverse effects on the project and the ability to raise complementary funds.

## INTRODUCTION

Project Concern International (**PCI**) began implementing the USAID-funded Child Survival VII (CS-VII) project in Maluku Province, Indonesia in 1991. Through this project, PC1 and the Department of Health worked together to improve immunization coverage and maternal and child health services in Maluku. At the time, this province had the lowest immunization coverage rate in Indonesia. The CS-X project builds upon the achievements of CS-VII in monitoring immunizations, training Traditional Birth Attendants, and improving attendance at integrated health posts (*Posyandu*). It also introduces some new activities, such as *Posyandu kader* training and immunizer peer training, as well as an HIV/AIDS prevention component.

**USAID** requires its PVO grantees to conduct a midterm evaluation, to assess progress in achieving results and provide recommendations for strengthening implementation and long-term sustainability. This report presents the results of a midterm evaluation of CS-X, which is scheduled to end in August 1997. The evaluation was conducted from April 30 to May 14, 1996, nineteen months after the start of project implementation. Results presented are largely qualitative, and are based upon information obtained from project documents, interviews with PC1 and government **staff**, and observation of a limited number of project activities. (See Appendix 1, Scope of Work and Schedule for Evaluation.)

The evaluation team consisted of a staff member from the central immunization section of the Department of Health, Government of Indonesia; a health technical advisor from the **USAID** mission in Jakarta; and the technical support officer from PC1 headquarters in San Diego. **PCI/Maluku** staff, usually the Project Director and/or the Senior Project Manager, were present at all interviews and observation sessions. The evaluation team attended all scheduled activities, compared impressions and formulated recommendations together. The team members **from USAID** and PC1 drafted and distributed a preliminary report. Comments from the Department of Health team member and **PCI/Maluku staff** were incorporated into this final report, which has been distributed to PCI, USAID, the MOH, and other interested parties.

The report is organized into the following six sections: immunization program support; *Posyandu* implementation; *Posyandu* attendance; health education; HIV/AIDS awareness and sustainability. These sections roughly correspond with major CS-X project objectives. Some sections also discuss CS-VII activities which were meant to be sustained beyond the life of this predecessor project.

As always, the evaluation team was constrained by several factors. CS-X is a large project with many components. It covers a geographical area that is roughly the size of Pakistan. As the evaluation was conducted over a two week period, it was possible to see only a limited number of project activities and implementation sites. Therefore, it was necessary to rely heavily on project data, supplementary documentation and secondary information to gain an understanding of the project's accomplishments.

## **L IMMUNIZATION PROGRAM SUPPORT**

### A. Background and Accomplishments to Date

Immunization for both mothers and children is the central intervention of CS-X. PC1 has therefore devoted considerable attention to strengthening Maluku's immunization program, and has introduced several innovative strategies. *MANISE* is a computerized database system which facilitates routine compilation and reporting of immunization coverage data. Provincial and district health office staff who have received *MANISE* training are now using it to compile and analyze immunization coverage data submitted by sub-district health centers. Before the introduction of *MANISE*, immunization coverage data were compiled through a more cumbersome process of manual tabulation, which is still used at the health center.

Rather than replacing the government's local area monitoring system (LAM), *MANISE* improves upon it. This obviates the need to introduce a new system into the government infrastructure. Further, PC1 has found that Department of Health **staff** can master the program in about an hour. Staff who use *MANISE* report that it is convenient and easy to use. Since *MANISE* has been introduced, there are fewer delays in reporting to upper administrative levels. Finally, *MANISE* makes it possible for district and sub-district officials to identify areas within their jurisdiction where immunization coverage is lagging, and to compare their performance in achieving immunization coverage with that of other areas covered by CS-X. In all of these ways, *MANISE* is helping the Department of Health to strengthen the province's health service delivery system.

Results from a cold-chain survey conducted under CS-VII indicated that some health center immunizers were having difficulty meeting coverage targets. To address this problem, PC1 developed a peer training program, in which 'high-performing' (as measured by local immunization coverage) immunizers spend a week working together with 'low-performing' or new immunizers. The assumptions are that immunization and cold chain management skills are best learned on-the-job and from peers familiar with the daily challenges of service delivery and management. Fifteen peer training visits have been carried out to date, and preliminary results indicate that these assumptions are correct.

A recent evaluation by the BASICS project demonstrated this program's effectiveness. In those areas where peer training had occurred, the average number of vaccine doses given increased by approximately 40% in the ensuing 12-month period. Participating health centers also rose in their rankings relative to all health centers, and demonstrated a substantial improvement in their cold chain management practices. Immunizer knowledge and practices also improved. For example, one immunizer reported that he and many of his peers had difficulty understanding how to implement the government's LAM system, even after participating in an official training course. He reported that the peer training approach gave him an opportunity to focus on understanding and skills acquisition, making it easier for him to operate the LAM. In addition, this immunizer now provides related information and education to mothers and village leaders as a routine part of service delivery. This type of program may also be used to improve the performance of other

kinds of health workers.

The peer training program is inexpensive to operate. It costs approximately \$53 dollars to train one immunizer. Several district health offices have recently taken over implementation of this program, and some have taken steps to include it in their annual budgets. It is a program that could probably be replicated effectively in other provinces in Indonesia.

Under CS-VII, PC1 developed a lifetime tetanus toxoid (TT) card and supported the implementation of a national policy which expands the target population for TT immunization coverage to include all women of reproductive age. (The previous policy only targeted pregnant women.) To date, PC1 has printed five hundred thousand paper lifetime TT cards, of which three hundred seventy thousand have been distributed. In addition, UNICEF is making arrangements to produce a large number of lifetime TT cards made of durable plastic, and begin distributing them in 1996. They have identified a corporate sponsor to support the printing of the cards, beginning in September.

1995 marked the beginning of a three-year government effort, called Pekan Imunisasi Nasional (PIN), to eradicate polio in Indonesia. Two sweeping immunization campaigns will be conducted in September and October of each year, so that every child under age five may be immunized against polio. To maximize coverage during the PIN, PC1 developed the **Pasukan Murid PIN**, or PAMUPIN, program in which fourth, fifth and sixth grade students help register mothers with children under five, and then escort them to the nearest immunization post during the PIN. Approximately ten thousand instructional brochures were distributed to elementary school teachers, who used them to help students mobilize mothers in villages throughout Maluku. The Ministry of Education and Culture allowed students participating in PAMUPIN to take leave from school on the day of the PIN.

PAMUPIN was instrumental in increasing polio vaccine coverage during the PIN. In areas where PAMUPIN was implemented, 94% of children targeted were immunized, as compared with an average immunization rate of 83% for areas without PAMUPIN.

Like the School *Posyandu* Program (PPAS), PAMUPIN is an innovative strategy which taps into abundant youth resources. Participating students are enthusiastic about the mobilization effort, and mothers reported that it was difficult to resist these persistent “student soldiers”. PAMUPIN is also another example of effective collaboration between PC1 and the Department of Health and the Ministry of Education and Culture. Although not originally a part of CS-X, PAMUPIN was developed by PC1 to **further** strengthen an important government initiative.

Finally, to improve neonatal tetanus surveillance, PC1 developed a pictorial form which Traditional Birth Attendants (**TBAs**) can use to record whether a baby died within the first month after birth. TBAs submit completed forms to their local health center midwife. Since tetanus is a principal cause of neonatal death, this notification form alerts health center **staff** to the likely possibility of a neonatal tetanus death. They are in turn expected to confirm whether tetanus was the cause of death and, if so, conduct a vaccination campaign in the village. The team was unable



to fully evaluate the effectiveness and impact of this reporting system, but feels that it could help strengthen neonatal tetanus surveillance. No information was available on how the forms are being used to confirm suspected tetanus cases, but **TBA**s are filling them out without difficulty and submitting them to the health center midwives.

### B. Concerns and Recommendations

1. While **MANISE** facilitates reporting at the district and provincial levels, it is still dependent on data received **from** the individual health centers. Health centers are often late in submitting these data, as they still have to tabulate them manually. It will be some time yet before computerized monitoring systems can be introduced in individual health centers.
2. The provincial Department of Health office has dedicated a separate computer for running **MANISE**. This arrangement limits the possibility of the system becoming infected with viruses. In contrast, district Department of Health staff have been using one computer for several purposes, and they have had problems managing viruses. As a result, the **MANISE** program occasionally gets jammed, and PC1 **staff have** been called upon repeatedly to clean these computers. In June, PC1 staff in these District offices received computers and training, to allow them to support the MOH **staff**. Since then PC1 staff report that the MOH has had far fewer problems with viruses.
3. One sub-district government **staff** member was uncomfortable with the current name of the immunizer peer training program ("*jurim-latih-jurim*", or "immunizer training immunizer") and requested that it be changed, as he felt it reflected negatively on the "host" health center. The team has no problem with the program's name being changed.
4. As TT lifetime cards are made of paper and must be kept for several years, there is a potential problem in their being mutilated. Therefore, the team supports the production and distribution of durable plastic TT cards. Some MOH staff felt that the health center rather than the mother should be charged with keeping the cards on file, to prevent their being lost, and could then bring them to the *Posyandu* sessions. PC1 **staff** strongly disagreed with this view, noting that mothers have kept their children's Road-to-Health cards at home for years without problems. Further, if the mothers keep the TT cards, they can get TT immunizations anywhere--not just the *Posyandu* or health center. Plus they can carry them with them when they move.
5. Involvement in PAMUPIN implementation was limited to 20% of fourth, fifth and sixth graders in 30% of the province's sub-districts. School principals reported that they did not have **sufficient** time to implement PAMUPIN, as the program was introduced only two months before the PIN. With the next PIN campaign scheduled for September/October 1996, there should be adequate time this year to improve PAMUPIN implementation. PC1 has recently carried out social marketing activities designed to increase attendance at the 1996 PIN, including producing and distributing 120,000 identifying arm bands to be worn by the students during their duty escorting the mothers to the PIN post, and producing a song, the "**PAMUPIN** March", which was professionally recorded and broadcast over the government radio station.

## II. **POSYANDU** IMPLEMENTATION

### A. Background and Achievements to Date.

*Posyandu*, or integrated health posts, are supposed to be conducted one day each month in every village. Village volunteers, known as *kaders*, organize and conduct the *Posyandu*. Assistance and supervision are provided by health center **staff**, usually immunizers and midwives, who visit the *Posyandu* and bring vaccines, rehydration salts, record books and other supplies. Failures in *Posyandu* implementation are common in Maluku. It is estimated that only 75-85% of the villages hold monthly *Posyandu*. *Posyandus* are less likely to be held in villages which are far from the health center and lack trained *kaders*.

To improve *Posyandu* implementation, PC1 had planned to train 10,000 *kaders* under CS-X. The provincial Department of Health was supposed to support this effort, with funds provided by the World Bank's Community Health and Nutrition III project. To date, these funds have not been made available, and PC1 is now seeking alternative sources of support. **AusAID** recently provided a small grant that will allow PC1 to train ten *kaders* in each of 100 villages. Nonetheless, the target for this training activity will be substantially reduced. Based upon the success of the immunizer peer training program, PC1 is also planning to use a similar model to reduce drop-out and improve the general quality of the *Posyandu*. The first *kader* peer training sessions, covering three sub-districts, will be conducted from June to August, 1996.

*Posyandu* Management Teams (**PMTs**) were created in response to a 1990 government decree. Their purpose is to ensure *Posyandu* implementation and attendance. Under CS-VII, PC1 contributed to this government initiative by training provincial, district, sub-district and village level PMT representatives in *Posyandu* supervision.

The school *Posyandu* program (PPAS) apparently also has the effect of improving *Posyandu* implementation. The evaluation team was advised that, in those villages where PPAS has been introduced, community mobilization for the *Posyandu* is greater, and health center **staff** feel compelled to make an extra effort to visit those *Posyandu*. (See section III for further assessment of the PPAS.)

### B. Concerns and Recommendations

1. To compensate for the lack of resources for *kader* training and address persistent problems in *kader* performance, the team recommends that PC1 follow through with their idea of piloting a *kader* peer training program. Judging by results from the immunizer peer training program, this model may also improve *kader* knowledge, skills and motivation. However, if results achieved through CS-X are to be sustained, the Department of Health must follow through on its training plans and resource commitments.

2. Turnover among PMT representatives is a persistent problem which compromises this body's viability and effectiveness in monitoring *Posyandu* implementation. Continuity is lost as team

members are transferred to other jobs. As a result, the provincial PMT and many sub-district **PMTs** are no longer active. District **PMTs**, however, seem more active; four out of the five have formed social marketing sub-committees, and three run monthly radio *Posyandu* quiz shows (a fourth will start in September). Finally, many PMT members argued that budget constraints prevented them from providing adequate supervision of *Posyandu* implementation.

Given these problems, PC1 has questioned what role these teams play, and considered reducing its support in keeping them active. However, based upon interviews with district and sub-district PMT representatives, the evaluation team feels that **PMTs** do play a role in helping to mobilize resources and coordinate logistics for *Posyandu* implementation. For example, when its motor boat broke down, one subdistrict PMT made arrangements with another subdistrict PMT to borrow a boat, so that health center staff could continue to attend *Posyandus*. Similarly, one district PMT informed subdistrict leaders about the school *Posyandu* program, and encouraged them to support it. As PMT representatives are usually mid- to senior government officials, it seems logical that they can facilitate this type of mobilization and coordination.

However, the potential contribution of the PMT to improving the quality of *Posyandu* implementation and increasing attendance seems more limited. PMT representatives could not provide similar examples of how they had contributed to these goals. Here their answers were more abstract, and less useful.

The CS-X project design includes a PMT assessment, which is to be conducted by the provincial PMT. Provincial PMT representatives assured the evaluation team that they intended to conduct this assessment soon, with technical assistance from PCI. Pending the results of this assessment, it is recommended that PC1 pursue alternative strategies for improving *Posyandu* implementation and attendance which have proven to be much more effective, while supporting the **PMT's** strengths in resource mobilization and coordination.

### **III. POSYANDU ATTENDANCE**

#### A. Background and Achievements to Date

Through the school *Posyandu* program (PPAS), fourth graders are receiving health education, and then using it to help mobilize mothers with children under three to attend the *Posyandu*. First introduced under CS-VII, significant increases in *Posyandu* attendance and immunization coverage were measured in villages where PPAS was piloted. Average *Posyandu* attendance increased from 33% to **77%**, and complete immunization coverage among children one to two years of age increased **from** 33% to 88%. In addition, pre-and post- implementation surveys indicated that mothers' knowledge of a range of nutrition and health issues had increased.

It is clear that a great deal of careful thought and preparation has gone into the development of PPAS. Program implementation is supported by the availability of high-quality materials, including a teacher's guide and student workbook. The innovative curriculum employs a participatory approach. Students are required to conduct mini health surveys, interview mothers

about diet and nutrition, and observe a *Posyandu* session.

CS-X is implementing PPAS in an additional 624 schools in 52 sub-districts throughout Maluku. In September/October, of last year, 50 sub-district teachers were trained to become trainers. They each, in turn, trained five teachers and five principals in their areas. Teachers and principals then implemented the school *Posyandu* curriculum in their fourth grade classes between November and February. A second phase of PPAS implementation, scheduled for September/October of this year, will train an additional seven teachers and principals in each of the 52 sub-districts.

The success of the Maluku PPAS program has attracted the attention of the World Health Organization, who requested Dr. Robinson to prepare an article on the topic for publication in *EPI Update*, a newsletter issued by WHO's Expanded Program for Immunizations office. The article should appear in late 1996.

Several social marketing campaigns are also helping to increase *Posyandu* attendance. The social marketing subcommittees of district PMTs in North Maluku, Central Maluku and Ambon are carrying out monthly radio quiz shows for *Posyandu kaders*, an idea first developed by PC1 in CS-VII. Three teams of three *Posyandu kaders* from different villages within the district compete 'head-to-head' in answering questions about mother and child health, and *Posyandu* implementation. These competitions are broadcast by radio to audiences throughout the district and beyond.

Finally, PC1 has developed several additional social marketing initiatives using a variety of mass and small media. Bumper stickers promoting tetanus toxoid immunization have been produced and distributed throughout the province. The evaluation team saw several of them pasted on public vehicles in Ambon, Temate and Morotai. Muslim and Christian religious leaders have been recruited to relay health education messages and encourage *Posyandu* attendance. PC1 has also developed newspaper crossword puzzles, and organized promotional walks and a "squash polio" squash tournament, in order to promote health education and *Posyandu* attendance. While there is no concrete evidence documenting the long term impact of these strategies, they are clearly creative, and help to raise awareness about maternal and child health and the *Posyandu*.

## B. Concerns and Recommendations

1. CS-X was to include a refresher training for 1,500 TBAs who received initial training under CS-VII. In addition, PC1 intended to use the refresher training to provide additional training in measles and polio surveillance, nutritional screening, and Vitamin A supplementation. As of late 1995, PC1 had made arrangements to train ten district-level midwives and one hundred health center midwives as trainers for the TBA refresher training. UNICEF pledged funding for the refresher training, pending Department of Health approval. This approval never came through, and now it is too late to complete the TBA refresher training before CS-X ends. PC1 has therefore decided to cancel the training.

**TBA**s in Maluku are an important resource for health education and service delivery. A significant opportunity to further strengthen their ability has been lost with the canceling of the refresher training. It is recommended that PC1 try to find alternative sources of support for TBA refresher training, and, in the meantime, continue working with the Department of Health to find a way to let the midwife trainers who have already been trained conduct TBA refresher training. PC1 should also investigate the possibility of obtaining a no-cost project extension **from USAID** to allow adequate time to complete the TBA training.

#### **IV. HEALTH EDUCATION**

##### **A. Background and Accomplishments to Date**

Through this project, PC1 is implementing a range of activities which are providing training and materials to a variety of organizations. The training-of-trainers (TOT) approach is a primary strategy used in the project.

Health education modules have been developed for diseases targeted by this project, including diarrhea, ARI and HIV/AIDS. In addition, PC1 has developed a module for adult education, which it uses to provide trainers with a basic orientation to adult education techniques. The team was unable to adequately assess the quality of the modules, due to limitations in proficiency in Bahasa Indonesia. However, a preliminary review of the materials suggests that they are appropriate, comprehensive, and of high quality.

These modules are being used to support the implementation of a comprehensive training plan. PC1 is working jointly with the Department of Health and the Ministry of Education and Culture to conduct a series of TOT courses for health educators, midwives, *Posyandu* Management Team (PMT) **staff**, PKK representatives, and other provincial and district government officials. In addition, the Department of Health and other government officials are receiving computer training, as part of overall training in the use of health information systems developed by the project. Finally, in expanding the implementation of the School *Posyandu* Program (PPAS), PC1 is training more teachers, principals, and district health education representatives to use this effective curriculum.

Implementation of the training plan is on track, and it is expected that PC1 will meet most of its targets by the end-of-project (see Appendix 4, CS-X Project Achievements). To date, representatives from 4 districts, 21 island groups and 100 health centers have received health educator training. Fifty sub-district supervisors, 257 teachers and 257 school principals have been trained to implement the PPAS. **As** a result, 6,600 more students are now involved in this program. (See below for achievements to date in implementing HIV/AIDS training).

The team cannot provide substantial comments on the quality of the training provided, as it was unable to observe any sessions. However, the team did interview several individuals who participated in health educator, school *Posyandu* and HIV/AIDS training. All those interviewed reported that the training had strengthened their ability to carry out their jobs or management

responsibilities related to the project implementation. In general, however, the training seemed to have relatively less impact on individuals who are involved in the project in a supervisory or management capacity, and more impact on those who are directly providing health education to mothers and/or children.

All delays in implementing the training plan are or have been due to circumstances beyond **PC1's** control.

## B. Concerns and Recommendations

1. In general, the PPAS continues to be an overwhelming success, as reported to the evaluation team in interviews with provincial and district government representatives, participating school **staff** and students, PMT representatives, and *Posyandu* and health center **staff**. The team's visit to observe the PPAS in Temate confirmed this impression.

During a second site visit to Daruba, Morotai, however, the team found problems with PPAS implementation. **After** four months of implementation, the students had only completed the first lesson of a sixteen lesson curriculum. In addition, there were several mistakes in how the students had conducted the mini-survey lessons contained in the workbook, and these mistakes had apparently not been corrected by the teacher.

When questioned about poor implementation of the program, *thepenilik* and teacher cited two reasons: (1) that the children had trouble learning the materials, and (2) that perhaps the teacher had not devoted enough time and attention to the program. Daruba is in a relatively remote part of Maluku province, and the general quality of education is most likely lower than in Ambon and other, larger towns. Therefore, it is possible that the children in Daruba are having more difficulty mastering the PPAS curriculum. PC1 staff, however, felt this was not due to any deficiencies in the students, since they had not come across this problem in other, remote locations throughout Maluku.

It was clear that the school **staff** had not invested sufficient time and attention to PPAS implementation, which speaks to a weakness in the program's supervisory mechanisms. The *penilik* is charged with ensuring that the curriculum is being taught by the teachers. There seemed to be a lack of follow-up support **for peniliks** and teachers, especially during the initial stages of program implementation, **when peniliks** and teachers are most likely to encounter problems in training teachers and introducing the program to students, respectively. It is recommended that PC1 provide closer supervision to the program during its implementation from November to March. To assist with this supervision, PC1 recently developed a checklist, which is now being used in the training of teachers by PC1 and **the peniliks**.

2. Government counterparts involved in PPAS implementation provided the team with further information on financial and management support for the program. The *penilik* in Daruba reported that he could not reach the schools in his area because there is no budget for transportation. The health center doctor in Daruba reported that he was confused about the

difference between the School Health Effort (UKS) and PPAS. He had been involved in the implementation of the UKS, but not the PPAS. Finally, the principal of the school in Temate suggested that the PPAS could be improved if health center doctors and staff could be more involved in PPAS implementation.

The current project design designates responsibility for supervision of **the peniliks** to the district level representative from the Ministry of Education and Culture. Based upon its observations in Temate and Morotai, the team agrees that this supervision has not yet happened, and that it probably would not be very beneficial anyway.

It is recommended, instead, that PC1 work with health center staff at the sub-district level to supervise the **peniliks** and teachers. Several individuals requested greater involvement of health center staff in PPAS implementation. The health center has resources available for transportation, and its staff reside in the sub-district. Health center staff have more specialized knowledge of health concepts than the teachers, and may therefore help to strengthen the health education component of PPAS. Finally, in helping to implement PPAS, health center staff may develop an even greater appreciation of this program's contribution to increasing immunization coverage.

While the district level representative from the Ministry of Education and Culture may play a peripheral role in supervision of PPAS implementation, this person is still needed for overall program management and coordination (see recommendation #3).

3. The Government of Indonesia has issued a policy that fifth and sixth graders are to receive general health education. A special budget has been provided for this national level health education effort (UKS), and several government sectors - including Health, and Education and Culture - are responsible for its implementation. Management of this effort is being successfully carried out by an intersectoral management team (Tim Pembina UKS).

PPAS and UKS are separate programs, because the students and the health topics covered are different. This should remain the case for implementation of these two programs. However, given the difficulties involved in introducing new programs and management systems into the government, PC1 and its government counterparts may want to consider extending the preexisting UKS management system to cover PPAS. It already functions effectively; has a special budget; and involves provincial and district level government **staff** from the Department of Health and the Ministry of Education and Culture.

4. PC1 is currently developing a supervisory checklist for PPAS. The design of this checklist should reflect any refinements in PPAS management and implementation made in response to the above recommendations.

## V. HIV/AIDS EDUCATION

### A. Background and Accomplishments to Date

The primary project objectives for HIV/AIDS are to increase the knowledge of health staff and people of reproductive age about the etiology of AIDS, how it is and is not transmitted, and how it can be prevented.

In this project, PC1 is expanding its HIV/AIDS experience to include the provision of village-based prevention programming; while **PCI's** local partner NGO, Lembaga Partisipasi Pembangunan Masyarakat (**LPPM**) is **further** establishing its track record in this area.

PC1 conducted a baseline HIV/AIDS KAP survey of 960 community members and health center **staff** in February, 1995. The results have been analyzed and compiled. In general, they indicate a very low level of HIV/AIDS knowledge among both community members and health center staff. In response to these results, PC1 is now implementing a series of training-of-trainer courses for health center **staff**, including health educators and midwives. To date, 3 **staff from** each of 100 health centers have been trained. PC1 is well on its way to reaching its target of training staff representatives **from** 135 health centers.

These HIV/AIDS trainers will in turn conduct a series of seminars for leaders from approximately 1,500 villages throughout the province. Village leaders then serve as resource people for community members who seek information about HIV/AIDS. These seminars have been postponed, pending the availability of **funds**. PC1 reports that it will be able to conduct the seminars in June, 1996. The success of this project component will depend on their being able to follow through with the village seminars.

The team is unable to provide specific comments on the quality and effectiveness of the HIV/AIDS training, as the team was unable to observe any sessions, and the program is still in the initial stages of implementation.

### B. Concerns and Recommendations

1. While increasing knowledge about HIV/AIDS is a necessary first step in preventing transmission of the disease, the impact of this intervention will be minimal **if it** is not supplemented with additional interventions to promote behavior change and improve STD management. The importance of including STD interventions as an integral part of HIV/AIDS prevention programming cannot be overemphasized. Current evidence clearly suggests that these interventions are crucial to **successful** HIV/AIDS prevention.

The current epidemiology of HIV/AIDS in **Maluku** also warrants a broader focus on **STDs**. Few people in this province have seen a case of HIV/AIDS, while, according to anecdotal evidence, many people have experience with other **STDs**. Insofar as STD is a relatively more identifiable illness experience for people in Maluku, it will prove to be an effective focal point for



interventions aimed at reducing risk behavior for all **STDs**, including HIV/AIDS.

The team therefore recommends that **PCI/LPPM** incorporate behavior change communication and STD management interventions into ongoing project activities. This will not only increase project impact, but also provide LPPM with the opportunity to further develop its capacity to provide comprehensive HIV/AIDS programming.

Interventions developed do not necessarily have to focus on improving the clinical management of other **STDs**. Given the fact that PC1 cannot implement clinically-based interventions, the team recommends that PC1 focus instead on implementing interventions which address STD risk and treatment-seeking behavior. The first step in doing this will be to get more accurate behavioral survey data. Behavioral surveys may also be designed to include information on the prevalence of **STDs** in Maluku. This information will be limited, but sufficient for the development of behavioral interventions. It is not recommended that PC1 undertake any kind of STD prevalence surveillance in Maluku.

Survey data will help PC1 identify which community groups are most appropriate for providing STD prevention and related behavior change interventions. Based on interviews and observations conducted during the evaluation, the team agrees that traditional birth attendants are a promising resource for implementing prevention interventions, as they already have the trust of community members, especially married women. However, PC1 should also pay special attention to identifying appropriate resources for providing STD prevention interventions among men.

Technical assistance for implementing this recommendation is potentially available through PCI, AIDSCAP and/or **USAID**. Also, as several international donors begin working with the government to implement the National HIV/AIDS Program, LPPM staff will have several opportunities for additional training in behavior change communication and STD prevention, and for networking with other **NGOs** throughout Indonesia who have expertise in these areas. PCI, AIDSCAP and USAID can provide LPPM with **further** information on available opportunities.

2. **As** it further develops its strategy for providing village-based HIV/AIDS education in Maluku, PC1 may find it helpful to look at other village-based models which have been developed and tested throughout Asia. Carol Jenkins' work with Papua New Guinea villagers (through the Institute for Medical Research in Goroka, PNG) may be most useful. The **USAID/Jakarta STD/HIV/AIDS** Advisor can also provide information on other organizations and individuals who have developed village-based HIV/AIDS models.

These models will have to be tailored to Maluku, but they offer some valuable lessons learned. In general, they discuss constraints to behavior change characteristic of rural areas, and highlight the importance of participatory and interpersonal approaches in overcoming these constraints. Through its work in Maluku, PC1 can make an important contribution to ongoing work in this area.

## VI. SUSTAINABILITY

### A. Background and Accomplishments to Date

Rather than providing services directly, PC1 is working with a variety of government and nongovernment organizations to improve their capacity to deliver maternal and child health education and services. Therefore, institutional development is a central theme of this project, and a number of potentially successful outcomes may already be seen.

A local NGO, LPPM has been created by the Indonesian staff of **PCI/Maluku**. LPPM represents one of the few NGOs active in health development in Maluku, and has already attracted almost 80 million Rupiah in external support to implement activities (See Appendix 7, LPPM Funds Received). It is also in the process of implementing a comprehensive staff training plan (See Appendix 8, LPPM Training Plan).

LPPM has already created a niche for itself in the area of HIV/AIDS. **PCI/LPPM staff** have played a central role in implementing the HIV/AIDS component of this project. Further, LPPM staff have conducted 8 additional HIV/AIDS seminars, reaching an additional 1,608 participants with HIV/AIDS education training. These seminars were paid for by the government and non-government organizations that requested them.

PC1 appears to have a generally good working relationship with provincial and district level **staff from** the Department of Health, and the Ministry of Education and Culture. PC1 and government representatives have together strengthened the implementation of a number of pre-existing reporting and management systems. In addition, many government officials have participated in the various training activities supported by this project.

Both the Department of Health and the Ministry of Education and Culture in Jakarta have expressed interest in replicating some of the new health information systems and health education models which have been piloted through this project. Specifically, the Department of Health/Jakarta is considering introducing **MANISE** in other provinces, and then using it to compile data from all provinces. To this end, BASICS recently awarded a grant to PC1 to make a generic **MANISE** program which could be used in other provinces and at the national level. PPAS has been formally incorporated into the fourth grade curriculum in Maluku province. PC1 is now working to replicate this program in Irian **Jaya** and Sulawesi; and the Ministry of Education and Culture is interested in making it a formal part of the national fourth grade curriculum. Finally, PC1 is working with Department of Health staff to determine the most efficient way to make the transition to **TTx5**, and North Maluku will serve as a pilot area in this effort.

Finally, the team found the quality and quantity of data collected for this project to be exceptional. Comprehensive baseline surveys and pre- and post-test evaluations have been or will be conducted for all aspects of this project. In conjunction with the baseline survey, PC1 carried out a province-wide infant mortality rate survey--the first one ever attempted in Maluku, and only the sixth ever done in Indonesia at the provincial level. PC1 has clearly demonstrated a strong

ability to document results.

## B. Concerns and Recommendations

1. **LPPM's** identified mandate encompasses a diverse array of program areas, including **STD/HIV/AIDS**, Water and Sanitation, Income Generation, Legal Aid and Social Marketing. The team appreciates **LPPM's** basic understanding that problems faced by people in Maluku province are not experienced 'by sector'. However, over the next few years, LPPM should seriously assess its ability to develop expertise, compete for funding and manage the implementation of activities in this many program areas.

2. Survey questionnaires developed for HIV/AIDS focus largely on HIV/AIDS knowledge. They are appropriate for the stated goal of the project, and they have yielded information which is useful for the development of HIV/AIDS education training modules and materials.

However, additional survey data will be needed in order to add behavior change and STD interventions to the project. A number of protocols have already been developed for this. Specifically, AIDSCAP and WHO have developed and tested protocols for conducting surveys on HIV/AIDS risk behavior and STD treatment-seeking behavior, respectively. AIDSCAP, **USAID/Jakarta**, and/or the WHO representative in Jakarta can provide **PCI/LPPM** with copies of these protocols. The **USAID/Jakarta STD/HIV/AIDS** advisor can provide technical assistance in implementing them. Given the limited budget provided for this project through the CS-X grant, however, PC1 may be constrained from implementing additional surveys, and funding from AIDSCAP appears not to be forthcoming for this program.

## C. Constraints

This section discusses constraints affecting project implementation that are beyond **PCI's** control. While the team would like to offer suggestions for addressing these problems, it does not expect that PC1 will necessarily be able to implement them.

1. Two issues consistently raised during the project evaluation were (1) the inadequacy of orientation training and (2) the frequency of staff turnover for several government positions which are vital to the successful implementation and longer-term sustainability of the project.

With respect to the first issue, project-supported training is actually compensating for a lack of adequate government training. For example, the immunizer (*jurim*) in Daruba reported that he did not understand how to use the government reporting system until he received help from another, more experienced *jurim* through the *jurim-Zatih-jurim* project activity. However, the *jurim-Zatih-jurim* program does not solve the basic problem of inadequate government training.

Regarding the second problem, key government counterparts are being trained through this project and/or developing strong working relationships with PC1 staff, only to be transferred

to another province (where they may have no opportunity to use their new skills). Replacements **often** arrive months later, so they are never briefed by their predecessors about project-related activities and responsibilities.

It is beyond the scope of this project and PCI's control to fully address these problems, yet they do compromise the sustainability of many activities being implemented. **As** appropriate and feasible, PC1 may discuss these issues with government counterparts and identify potential solutions. The most obvious suggestions would be for PC1 to work with its government counterparts to (1) strengthen their orientation trainings, and link them more closely with project training activities, and (2) prepare briefing materials for their successors.

2. Another constraint to the sustainability of the **MANISE** program is the lack of computer culture in Indonesia, which may partly explain problems encountered in maintaining the computerized **MANISE** program. The project director is already sensitive to this issue and, partly for this reason, he has delayed the introduction the computerized vaccine checklist developed by the project.

The introduction and routine use of computers throughout Indonesia is inevitable, but it will take time. More remote and poorer provinces like Maluku will not have computer resources for some time to come. PC1 is therefore encouraged to continue giving special attention to computer training for Department of Health staff throughout the life of the project, in order to ensure that they can manage the computer effectively and, most importantly, check for viruses.

## **VII. OTHER ISSUES**

### **Project Management**

The evaluation team felt generally that the management of the Maluku Child Survival project is strong. Dr. Robinson and his staff have established administrative and financial systems which appear to facilitate the smooth functioning of project activities. For instance, daily staff meetings are held and a management-by-objective system is employed to ensure that tasks are clearly identified and responsible staff are assigned to carry them out. In addition, because of the vast geographic area of Maluku Province, Project Managers have been placed in north, central and southeast Maluku to coordinate activities in their respective districts. This seems to be an efficient way to ensure adequate oversight of local activities, and to more easily provide training and follow-up for local MOH **staff**.

**PCI/Maluku** has also invested heavily in the development of its staffs technical and managerial capabilities. All staff have participated in formal training courses lasting from 3 to 30 days, or conferences and informal meetings, within Maluku and elsewhere in Indonesia. Several staff have been promoted to more responsible positions, as their knowledge and skills grew. PC1 has also encouraged the Maluku staff to form a local NC&called LPPM--which can continue some of the work begun by PC1 under CS-VII and CS-X, as well as initiate new health and community development projects in Maluku. The evaluation team felt that these management and institutional arrangements will provide a solid foundation for the sustainability of PCI's health

development activities.

### Budget Management

The project is on track with its overall expenditure of USAID **funds** under the CS-X grant. As of June 30, 1996, a total of \$697,242 had been spent, out of the total USAID project budget of **\$1,190,635** (see Financial Pipeline Analysis in Appendix 9). Thus, after 21 months of project operation (which equals 58% of the project period), 59% of the grant had been expended. There is little possibility that the budget will be underspent at the end of the project.

The rate of expenditure for most of the individual **USAID** budget categories is on target. The exceptions are the Consultants and the Headquarters Travel/Per Diem categories, which are substantially underspent. Cost savings in the Consultant category are due largely to **PCI's** use of locally-available consultants for evaluations, rather than more expensive international consultants. The expenditures recorded for Consultants will rise somewhat as costs for the final evaluation and the PC1 audit are incurred and booked.

As the Pipeline Analysis shows, the PC1 match contribution to the CS-X project budget is underspent. As of June 30, 1996, \$63,746 had been spent, out of the total PC1 contribution budget of \$396,854. Thus, 16% of the match contribution had been recorded **after** 58% of the project period. The evaluation team understands that some locally-sourced, in-kind and cash contributions may have been received but not yet recorded as match contribution to the project, especially for the years 1994 and 1995. PC1 accounting **staff** intend to review records of in-kind contributions for these years to determine if further matching contributions can be booked. PC1 should closely monitor this issue during the remainder of the project.

### Trips Taken During the Reporting Period

The CS-X cooperative agreement requires PC1 to provide information in the midterm evaluation report on trips taken during the reporting period (September 30, 1994 to April 30, 1996). As this project is being implemented throughout the entire province of Maluku, Indonesia, there is almost continuous local travel taking place by **PCI/Maluku's** 20 staff members, and it is unreasonably burdensome to describe it all here. Travel outside of Maluku Province--to other parts of Indonesia and internationally--is described in Appendix 10. It has included training courses for **PCI/LPPM staff within** Indonesia, attendance at conferences, and visits to PC1 headquarters in San Diego.

## **APPENDIX 1**

### **Scope of Work and Schedule for Evaluation**

# **SCOPE OF WORK**

MID-TERH **EVALUTION** OF CS-X

## **MALUKU PROVINCE**

### **PROJECT CONCERN INTERNATIONAL**

#### **INTRODUCTION:**

Project Concern International (PCI) has been involved in health and development activities in Indonesia for over twenty years. In the fall of 1991, PCI began working in the Province of Maluku with support from a U.S.A.I.D. Child Survival VII (CSVII) grant.. This area was chosen by request of the MOH Director General for Community Health, Dr. Leimena, due to its delayed health development, and as the province had the lowest immunization coverage in all of Indonesia. The overall Child Survival Project design supported activities to improve Posyandu implementation and attendance focussing on improving immunization coverage while promoting the identification of high-risk births and appropriate diarrheal disease management. With favorable results the project received continued funding under Child Survival X (1994-1997). The extension builds on the success of the first project emphasizing improvement in **MOH** capability for health education, expansion of social marketing strategies, training of **Posyandu** staff and introducing HIV/AIDS interventions.

As part of the routine project implementation, PCI is required to undertake a mid-term evaluation; Unlike a final evaluation, this evaluation is not intended to focus on the quantitative accomplishments of the project. Rather, it is to be used to look at qualitative aspects of project implementation, and to review the strengths and weaknesses of on-going activities. It is hoped that the strengths, weaknesses and recommendations noted by the evaluation **team** will be used to further enhance continued project activities.

Project Concern International's mid-term evaluation **for its CSX** Project in Maluku Province will be undertaken from May 1 - May 12, 1996. The evaluation team consists of three members:

- 1) Partohoedoyo Soetaryo, MD, MPH  
Chief (retired), Sub-Directorate of Integrated Health  
Service Development  
Directorate General of Community Health  
Ministry of Health, Republic of Indonesia

- 2) Anne W. Scott, Ph.D.  
Health Technical Advisor  
Office of Human & Institutional Resource Development  
USAID/Jakarta
- 3) Jeffrey Billings, MPH  
Program Officer/Technical Support Officer  
Project Concern International  
California, USA

A representative from an IPVO (PATH/Indonesia) was to participate but a last minute change in his project schedule prevented him from being available.

#### REQUIREMENTS:

USAID/Washington (at this date) has not yet prepared the new Mid-term Evaluation Guidelines for CS-X, so the guidelines from CS-IX will be used in the meantime (copy enclosed). The evaluation team will use these guidelines to review the project and prepare a document for submission to USAID/Washington by May 31, 1996. The team will visit on-going project activities and interview principle officials involved in the project. Travel will be required, as the province is expansive and few activities are being conducted in Ambon alone. The first four days the team will be oriented and interview provincial and district level officials in Ambon. A schedule is attached. A trip is planned to North Maluku to witness several typical activities in the field and get an appreciation for the geographic situation faced by the project in achieving its objectives.

Since only 12 days are given for the evaluation, obviously only a limited number of program sites and activities can be viewed by the evaluation team. Therefore, the team must limit its statements to those where it felt the given information was adequate and refrain from making comments on issues that could not be adequately reviewed. It should be noted that the purpose of this evaluation is to review Project Concern International's CSX program and not to review any Indonesian Ministry of Health program.



The evaluation team members will be booked into the Ambon Manise Hotel, which is only 100 meters from the PC1 office. The hotel is a three-star hotel with swimming pool, tennis and squash courts.

The team will be provided an area in the PC1 office in which to review documents and work on the final document. Secretarial assistance, computers, FAX and e-mail will be available. Some project documents will be made available before departure to Ambon. Others will be available for review in the office.

Recreation is available on the week-end at several beaches on Ambon Island for bathing or snorkeling. PC1 will assist in arranging transportation.

Since this is a malaria-endemic area, it is recommended that the team members take prophylactic measures in addition to bringing mosquito propellant. Accommodations in N. Maluku will be arranged **so as** to minimize the chance of exposure, but this is not a guarantee of a mosquito-free visit.

PC1 will arrange all transport from/to Jakarta and locally.

## MID-TERM EVALUATION SCHEDULE

Monday April 29	Arrival of Jeff Billings and Anne Scott in Ambon. No activity planned. PC1 holiday (Idul Adha) - office closed. Rest and review materials at leisure.
Tuesday April 30	Dr. Rizal arrives. Evaluation team meets to review materials.
Wednesday May 1	Evaluation team meets <b>MOH/Maluku</b> officials Observe <i>Posyandu</i> Radio Quiz and meet Ambon <i>Posyandu</i> Management Team Orientation and review of evaluation plan Review of activities to date, with Project Director
Thursday May 2	Meet Provincial <i>Posyandu</i> Management Team representatives Briefing with LPPM ( <b>PCI's</b> local NGO) Review documents
Friday May 3	Review HIV/AIDS activities Witness <b>MANISE software</b> use
Saturday May 4	Meet Kakanwil Ministry of Education Rest or review project as necessary
Sunday May 5	Flight to Temate in morning Boat to <b>Daruba</b> , Morotai in evening
Monday May 6	Meet local MOH and MOE officials Visit <i>Posyandu</i> and School <i>Posyandu</i> Program
Tuesday May 7	Interview immunizer re: peer training program Interview health educator and health center doctor Depart for Halmahera by boat in afternoon
Wednesday May 8	Bus to Sidangoli via Tobelo Boat to Temate arriving late afternoon Meeting with Central Halmahera <i>Posyandu</i> Management Team and Health Educator
Thursday May 9	Observe North Maluku <i>Posyandu</i> Radio Quiz Visit School <i>Posyandu</i> Program in Temate Interview <i>Posyandu</i> Management Team Interview Kepala Dinas of <b>MOH/North Maluku</b>

Friday May 10	Flight to Ambon in morning Evaluation team discusses findings and begins drafting report outline
Saturday May 11	Evaluation team discusses findings and completes detailed outline Dr. Rizal departs
Sunday May 12	Rest
Monday May 13	Team (Anne Scott and Jeff Billings) <b>drafts</b> evaluation report
Tuesday May 14	Team drafts evaluation report
Wednesday May 15	Team completes evaluation report Anne Scott and Jeff Billings depart

## **APPENDIX 2**

### **List of Persons Interviewed**

## LIST OF PERSONS INTERVIEWED

### Ambon Maluku

Dr. Tamher	Ministry of Health Project counterpart
Dr. Umarella	Head of Provincial <b>Health</b> Service Department
Dr. Jopy Manupputty	Head of Provincial Health Education Section
Drs. Piet <b>Sohilait</b>	Member, Provincial Social Marketing Team
Dr. <b>Rukyia</b> Marasabessy	" "
Dr. Hadji Muna	" "
Ibu <b>Ima</b> Soamole	" "
Ibu Salampessy	" "
Drs. J. Wattimena	Head of Ambon Municipality Social Marketing Team
Bpk. Suafasihi	Head of Provincial Ministry of Education & Culture
Drs. John Tamaela	Secretary of Provincial Ministry of Education & Culture
Drs. AA. Parera	Head of the YPPK church organization

### Morotai. North Maluku

Dr. Eka Doddy Widayanto	Head of Daruba Subdistrict Health Center
Bpk. <b>Anis</b>	Supervisor for Ministry of Education & Culture, Daruba
Bpk. Kausil	<b>Immunizer</b> at Daruba Health Center
Bpk. Kanur	Health Education Section <b>staff</b> , Daruba Health Center
Ibu Pattiradjawane	Elementary School Principal, Suli Village
Ibu Frans	Elementary School Teacher, Suli Village

### Temate. North Maluku

Dr. Syarif Albaar	Head of District Health Services Department
Alwi Husein	Head of District Immunization Section
Ibu <b>Ati</b>	District Social Marketing staff
Drs. At-if	" "
Ibu Kakisina	Principal of Elementary School Teladan I
Bambang Siswanto	Health Education Section <b>staff</b> , Central Hahnahera District
Drs. Acing Salampessy	Social Marketing staff, Central Halmahera District

# **APPENDIX 3**

## **Project Objectives**

# PROJECT OBJECTIVES

	TARGET	BASELINE	ACHIEVED
1. Increase to 85% the proportion of children between 12-23 months of age who are fully immunized by 12 month of age (according to the LAM system) or to 70% by the WHO cluster-sampling system,	85 %	47 % (95)	
2. Increase to 30% the proportion of women with proof of receiving two doses of tetanus toxoid vaccine prior to the birth of her last child less than 2 years of age.	30 %	16 % (95)	
3. Increase to 30% the proportion of children under two who possess a Road-to-Health card.	80 %	56% (95)	
4. Increase to 60% the proportion of children under two who attend <i>Posyandu</i> each month	60 %	48 % (94)	
5. Increase to 65% the proportion of children under two with diarrhea in the past two weeks who were treated with ORT.	65 %	52 % (94)	
6. Increased to 25% the proportion of mothers of children under two who know at least two signs/symptoms of dehydration.	25 %	11 % (94)	
7. Increase to 35% the proportion of pregnant women who deliver assisted by a trained health worker (including trained TEA).	85 %	73 % (95)	
8. Increase to 25% the proportion of mothers who have proof of at least one antenatal visit prior to the birth of her youngest child under two years of age.	25 %	5%	
9. Increase to 30% the proportion of others who sought medical treatment for their infant/child less than two years old with cough and rapid, difficult breathing in the past two weeks.	80 %	67 % (95)	
10. Increase to 80% the proportion of health center staff knowledgeable about the proper WHO guidelines for ARI case management.	80 %	batal (cancelled)	

# PROJECT OBJECTIVES

	<u>TARGET</u>	<u>BASELINE</u>	<u>ACHIEVED</u>
11. Increase to 80% the proportion of provincial health staff who afford the knowledge about the exact WHO guidance for Acute Respiratory Infection (ARI) case management.	80 %	batal	
12. Increase to 30% the proportion of health centers with adequate and regular supply of antibiotics for treatment of ARI.	80 %	batal	
13. Increase to 70% the proportion of health centers'who know the etiology of AIDS PLUS at least two means of transmission AND at least two methodsd for prevention of HIV/AIDS.	70 %	32 % (95)	
14. Increase to 30% the proportion of people 15-49 years of age who know at least one mode of transmission AND at least one method for prevention of HIV/AIDS. ' .	30%	12% (95)	



## **APPENDIX 4**

### **CS-X Project Achievements**

# CSX PROJECT ACHIEVEMENTS

INPUTS	PLANNED		ACHIEVED		OUTPUTS	% OF TARGET
	NO.	DATE	NO.	DATE		
1. Baseline Survey						
KAP	X	IV/1 994	X	11/1995	Survey Report	100%
HIV/AIDS	X	IV/1 994	X	11/1995	Analysis complete	100%
HC staff KAP - ARI & HIV/AIDS	X	IV/I 994	X	11/1995		
2. Infant Mortality Rate Survey	0	unplanned	X	I/I 995	Survey Report	N/A
3. Detailed Implementation Plan	1	I/I 995	X	I/1 995	DIP completed/submitted	100%
4. Posyandu MT Assesement	X	I/I 995				
5. Health Educator Training - Large Island Groups	3 trainings	I/1 995	3	II/1995	4 district teams and 21 island groups (Ugroup)	100%
5. Health Educator Training - Small Island Groups	21 trainings	II/1995	11 trainings	III/I 995	100/1 35 health centers trained	74 %
6. School Posyandu Program prep - Subdistrict supervisor tmg	3 trainings	II-III/1995	3 trainings	II-III/1995	50 subdistrict supervisors trained (50/52)	\$6 %
- Teacher training	52 trainings	III/1995	50 trainings	III-IV/1995	257 teachers & 257 school principals trained	98 %
7. School Posyandu Program						
Phase I	262 schools	IV/95 - I/96	257 schools	IV/95 - I/96	6,600 4th grade students involved	98%
Phase II	624 schools	IV/96 - I/97				
8. Teacher training for Christian schools	0	unplanned	1 training	II/1 996	Teachers trained for 43 schools	N/A

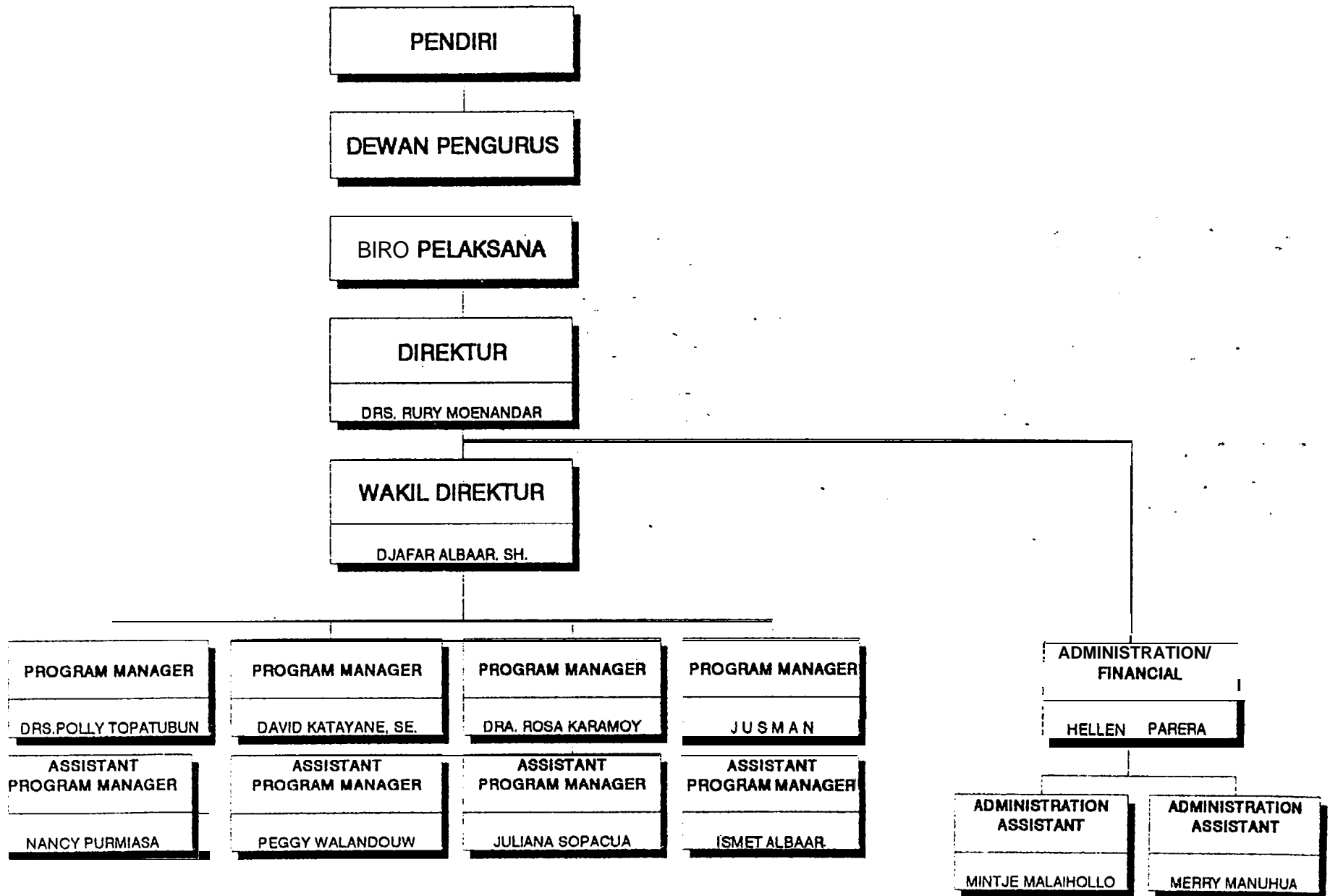
## CSX PROJECT ACHIEVEMENTS

INPUTS	PLANNED		ACTIVED		OUTPUTS	% OF TARGET
	NO.	DATE	NO.	DATE		
9. Computer training for HIS Coord.	X	II/I 995	3 weeks tmg	II/I 995	HIS Corrd. capable of servicing computers/training	100%
10. Peer immunizer tmg program	X	1995-97	10 tmgs	1995	10 immunizers trained BASICS study/evaluation	N/S
11. MANISE used for monitoring	X	1'99597	X	1994-I 996	MANISE functioning in 4/5 districts MANISE functioning in province level BASICS grant to expand	80% 100% N/A
12. HIV/AIDS village training - HC staff training	135 HC	III/95-IV/95	100 HC	III/1 995	3 staff/I-& (300 staff trained).	74%
- Village seminars.	35 seminars	IV/95-II/96	0	-	Postponed until 6/96	0%
13. Social Marketing program	X	1994-97	X	1994-97	Radio Quiz shows in Ambon/Temate TT bumper stickers distrib. 200,000 TT cards distrib.	N/S
14. TBA Refresher training	135 trainings	IV/95 - III/96	0	-	Activity cancelled by MOH/National	
15. Posyandu kader training	100 villages	I/96 - IV/96	0	-	Training delayed by MOH/PKK (will start 6/96)	0 %
16. PAMUPIN Program - School activity	0	unplanned	840 school:	III/95	Est. 37,000 student involved	N/A
- PIN /evaluation Survey	0	unplanned	x	IV/95	Document completed	N/A
17. HIV/AIDS seminars/workshops - 8 workshops	0	unplanned	X	III/95 - I/96	1,214 participants reached (see list of workshops)	N/A

## **APPENDIX 5**

### **LPPM Organization Chart**

# LPPM MALUKU ORGANIZATION CHART



## **APPENDIX 6**

### **LPPM HIV/AIDS Activities in Maluku Province to Date**

# SUPERVISION FORM IMPLEMENTATION HIV/AIDS ACTIVITIES IN MALUKU PROVINCE

NO	DATE	LOCATION	TOTAL PARTICIPATION	MATERIALS	REMARKS
1.	JULY-AUGUST	DISTRICT	191 PARTICIPANTS	HIV/AIDS TRAINING PACKAGE	TOT PKM
2.	20/09/1 995	AMB. MUNIC.	86 PARTICIPANTS	HIV/AIDS TRAINING PACKAGE	POLICE DEPARTMENT MALUKU
3.	1 I/ I/1995	AMB. MUNIC.	600 PARTICIPANTS	HIV/AIDS SEMINAR	GPM MOLLUCAN PASTORS
4.	25/11/1995	AMB. MUNIC.	54 PARTICIPANTS	HIV/AIDS TRAINING PACKAGE	POLITICAL PARTY MEMBERS' PDI
5.	28/11 /1995	AMB. MUNIC.	50 PARTICIPANTS	HIV/AIDS TRAINING PACKAGE	FAMILY WELFARE COMMITTEE & WOMEN ORGANIZATION AMBON MUNICIPALITY
6.	15/12/1 995	AMB. MUNIC.	150 PARTICIPANTS	HIV/AIDS SEMINAR	AMBON MUNICI. SERVICE OFFICIALS & STAFFS
7.	18-19/12/1995	MASOHI	40 PARTICIPANTS	HIV/AIDS TRAINING PACKAGE	MOSQUE & CHURCH YOUTH
8.	27/03/1 996	PIRU	43 PARTICIPANT;	"HIV/AIDS SEMINAR "	GPM YOUTH CAMP

TOTAL                      1.214 PARTICIPANTS

## **APPENDIX 7**

### **LPPM Funds Received**



## **LPPM FUNDS RECEIVED**

AUSAID (Posyandu kader training)	Rp 15,000,000
Jakarta Community Church Outreach Committee	Rp 1,200,000
EPOCH project	Rp 2,100,000
Maluku Health Service Department	Rp 1,500,000
New Zealand Embassy (School posyandu program)	Rp 60,000,000
<b>TOTAL</b>	<b>Rp 79,800,000</b>

## **APPENDIX 8**

### **LPPM Training Plan**

## STAFF TRAINING

NO.	NAME	LOCATION	DURATION OF COURSE	DATE	DESCRIPTION
1.	Rury Mocnandar Sr. Project Manager	University of Indonesia	4 days	January, 1995	Writing of Reports
2.	Djafar Albaar PM N. Maluku & Halteng	Jakarta	5 days	February, 1995	With SR to Embassy's & Other Donor Agencies
3.	Jusman HIS Coordinator	Aldcom in Jakarta	1 month	Mei, 1995	Computer Training
4.	Hellen Parera Executive Secretary	Yayasan Ind. Sejahtera/Sojo	9 days	June, 1995	Administration & Financial
5.	Rosa Kara'moy Social Marketing Specialist	P&K Office in Jakarta	-	July, 1995	Meeting with Minister of Education and Culture
6.	David Katayane PM C. Maluku & Ambon Munici.	University of Indonesia	7 days	October, 1995	Rapid Assessment
7.	Peggy Walandouw PM Assistant C. Maluku & Ambon Municipality	Ciloto in Jakarta	3 days	February, 1996	Review & Evaluation of Mother and Child Survival
8.	Rury Moenandar Sr. Project Manager	Hotline Surya/ Surabaya	7 days	March, 1996	Semiloka HIV/AIDS
	Nancy Purmiasa IEC Specialist	University of Indonesia	6 days	April, 1996	IEC Workshop